

A Community Defined Evidence Practice in Fresno, CA: The Hmong Helping Hands Intervention Project

by

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Abstract

Although past research has documented the presence of psychological traumas and mental illnesses among certain refugee and immigrant groups, much less is known about the kinds of interventions that can help to reduce mental illnesses among underserved and inappropriately served vulnerable populations such as Hmong former refugees. We describe an innovative community defined evidence practice project in Fresno, Merced, and Stockton, California and examine its impact on 104 Hmong adults' and older adults' mental health. Results showed positive outcomes for psychological improvements and maintenance of Hmong values despite Hmong participants' past experiences with numerous traumas. We argue that an intervention strategy that identifies and draws on a group's culture as protective factors and that is appropriately implemented by culturally and linguistically competent staff can have the potential to improve the mental health conditions of Hmong adults and older adults. By taking account of Hmong former refugees' experiences with historical traumas and by examining the impact of this culturally innovative health intervention on their mental health, our study makes an important contribution to the literature on immigrant and refugee trauma and mental health.

Keywords: Immigrant/refugee health intervention, psychological trauma, mental health, community defined culturally competent practice, Hmong Americans

Past research has found that Hmong refugees who arrived in the United States have experienced a wide range of physical traumas and mental illnesses. Their physical traumas and mental illnesses can be traced back directly to their experiences as soldiers or relatives of soldiers who fought (and died) in the U.S. Secret War in Laos between 1960 and 1975. Given that thousands of Hmong refugees have gone through this trauma, it was not surprising that many have experienced and are still experiencing conditions such as post-traumatic stress disorders, anxiety, and depression. However, what is less known but urgently needs to be understood, are the kinds of mental health interventions that can help to reduce these illnesses among the most vulnerable members of this population.

In this paper, we describe an innovative community defined evidence practice (CDEP) project in Fresno, California called the Hmong Helping Hands Intervention (HHHI) project and examine its impact on Hmong adults' and older adults' mental health. This CDEP project used a novel approach based on incorporating traditional Hmong cultural arts, practices, and beliefs that had worked in helping them to manage their daily stressors and build strong protective factors. We argue that an intervention strategy that identifies and draws on a group's culture as protective factors and that is appropriately implemented by culturally and linguistically competent staff can have the potential to improve the mental health conditions of Hmong adults and older adults. Below, we review the relevant literature on Hmong American mental health before describing the Hmong Helping Hands Intervention project and presenting the findings.

Background of Mental Health Problems in Hmong American Communities

The U.S. Department of Health and Human Services (1999) defines mental illness as "health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning" (p. 5). As political

refugees from war-torn Laos, Hmong endured decades of war and forced displacement and the physical and psychological traumas associated with war and displacement (Collier, Munger, & Moua, 2012; Vang, 2021). Once Hmong refugees immigrated to and resettled in the United States, they encounter new sets of physical, cultural, social, economic, and political environments which can shape their physical and mental health (Westermeyer, Neider, & Callies, 1989). Post-migration experiences such as poverty, racial prejudices, discrimination, and social isolation can increase stress and worsen their mental health. However, holistic, culturally relevant, community-based interventions that center (i.e., value, validate, support) the experiences, knowledge, and identity of immigrants/refugees may be able to alleviate some of the negative mental health outcomes in immigrant or refugee populations. As Goodkind (2006, p. 91) has pointed out, “Rather than an exclusive focus on therapy to deal with the past traumas that refugees have experienced, holistic interventions that address material, social, and educational needs and the challenges of living in a new country, as well as psychological needs, are important.”

Research conducted with Hmong refugees since their arrival to the U.S. in the mid- to late-1970s shows that many among them have experienced a wide range of physical and mental illnesses (Cha, 2003; Culhane-Pera, Her, & Her, 2007; Culhane-Pera, Moua, DeFor, & Desai, 2009; Gjerdingen & Lor, 1997; Himes, Story, Czaplinski, & Dahlberg-Luby, 1992; S. C. Lee & Chang, 2012; Perez & Cha, 2008; Reder, Cohn, Vangyi, Vang, & Vang, 1984; Tanjasiri et al., 2001; Thalacker, 2011; Voorhees, Goto, & Wolff, 2014; Wahedduddin, Singh, Culhane-Pera, & Gertner, 2010; Wong, Mouanoutoua, Chen, Gray, & Tseng, 2005; A. Yang, Xiong, Vang, & Pharris, 2009; R. Yang, Mills, & Nasser, 2010; R. Yang, Mills, & Riordan, 2004; R. C. Yang, Mills, & Riordan, 2005; Young, Xiong, Finn, & Young, 2013). Many of Hmong’s physical

traumas and mental illnesses can be traced directly to their experiences as soldiers or relatives of soldiers who fought and died in the U.S. Secret War in Laos. Between 1960 and 1975, the U.S. government authorized the Central Intelligence Agency to recruit Hmong into its secret army to fight communism (Xiong, 2022). As a result of the U.S. Secret War in Laos, tens of thousands of Hmong soldiers and countless civilians lost their lives and countless people were injured. Hundreds of thousands of Laotians, including Hmong, were displaced from their homes. After the fall of Long Tieng in May 1975, tens of thousands of Hmong sought refuge in Thailand. Eventually, over 100,000 Hmong became stateless refugees in Thailand (Xiong, 2022).

In Thailand, Hmong refugees were often put in barbed wire camps preventing them from having contacts with most people outside the camp. In Spring 1976, the first major wave of Hmong refugees was admitted to the U.S. They and later groups of Hmong refugees were met with a host of new traumas, including social isolation and culture shock. These traumas were compounded by nativism and ethnic/racial discrimination from some established residents, and by poverty, all of which affected their mental health.

In the United States, a number of research studies has found that mental health illnesses among the Hmong are much higher than the U.S general population and other Southeast Asian groups (Collier, Munger, & Moua, 2012; Frances & Kroll, 1989; Mouanoutoua, Brown, Cappelletty, & Levine, 1991; Westermeyer, 1988). A metasynthesis analysis study done by S. E. Lee (2013) found that depression was the most prevalent mental health issue among Hmong Americans, noting that in a sample of 225 Hmong patients:

80.4% of them were being seen for depression, compared to 11.8% for posttraumatic stress disorder, 3.5% for anxiety and somatoform disorders, 2.7% for psychoactive

substance use disorder, 2.0% for organic mental disorder, .8% for schizophrenia, and .4% for personality disorder. (p. 8)

Recently, Vang, Sun, and Sangalang (2021) conducted a review of the cultural and social factors in Hmong mental health, noting that Hmong adults and older adults continued to experience some of the highest rates of psychological distress and mental illnesses. M. S. Yang and Mutchler (2020) studied the depressive symptoms of older Hmong refugees in both Minnesota and California, with results showing more than 72% of the participants indicated they had symptoms of depression, suggesting that depression may be a lifelong experience for this high-risk population. Collier et al. (2012) confirmed the most common mental health conditions for Hmong refugees were consistent with depression, PTSD, anxiety, social stress, and acculturation difficulties. When compared to other Southeast Asian groups, Lee and Chang (2012) found higher rates of being diagnosed with depression for Hmong, and they also had the lowest help-seeking behaviors in utilizing Western healthcare, along with the lowest average happiness on a scaled assessment.

Barriers to Seeking Mental Health Treatment

Today, mental disorders continue to affect Hmong individuals, families, and communities in far-reaching ways, and this population still experiences significant mental health needs (Collier et al., 2012). Recent research has identified several barriers to Hmong's mental health care. These barriers include stigma, communication challenges, and mental health literacy (Vang et al., 2021). According to some Hmong individuals, the language barrier (i.e., the inability to speak English) and low literacy have also prevented or discouraged them from receiving health care treatment, including mental health care (Simpson, 2001). Furthermore, some Hmong have also cited discrimination as a barrier to using medical and mental health care

(Burgess, Ding, Hargreaves, van Ryn, & Phelan, 2008; Simpson, 2001). These findings are in line with past research which identified similar barriers such as cultural isolation and negative experiences associated with being refugees such as stress, loss, dislocation, poverty, and unemployment (Rowe & Spees, 1987). Despite these persistent barriers, group and community-based treatments and mental health interventions have yielded some hopeful results (Goodkind, 2006; Vang et al., 2021). Goodkind (2006) suggests that culturally relevant community-based advocacy and collaborative learning opportunities provided to Hmong participants had positive, albeit limited effects on participants' mental health.

Culture as Protective Factors: The Hmong Helping Hands Intervention as Community Defined Evidence Practice

Although many evidenced-based practice (EBP) mental health treatments have been established, there are questions about their applications and effectiveness in ethnically and culturally diverse communities given that the samples used to establish EBP status usually contain inadequate representation of diverse ethnocultural groups (Aisenberg, 2008; Hall, 2001; Sue et. al., 2009). In establishing many of these EBPs, much of the worldviews of indigenous and non-Western groups around the world were not part of the process. At the same time, some EBP treatments were so narrowly defined that other forms of evidence were not included in defining "evidence-based practices" (Martinez, Callejas, & Hernandez, 2010). In addition, there are few adaptations of these EBPs for various ethnocultural groups, which leads to questions of the effectiveness of these treatments in various culturally diverse groups and of alternative ways of showing "evidence" (Abe et al., 2018). Given these limitations with EBPs, an alternative method called practice-based evidence (PBE) has emerged to address this gap. As opposed to EBP's top-down approach to mental health interventions, PBE emphasizes a bottom-up

approach—that is, PBE emphasizes practices that are defined by a community as culturally relevant to its members (Abe et al., 2018). It is gaining momentum as a new concept and model for generating “evidence” about how communities of colors define efficacy in their community (Martinez et al., 2010).

Community-defined evidence practice (CDEP) is a refinement of PBE to address the need to recognize and test community-based practices that “work.” It not only refines the concept and definition of PBE, but more importantly helps to validate research models to determine “evidence” from the community’s perspective (Martinez et al., 2010, p. 12). Such practice was implemented statewide in California to alleviate mental health disparities. From 2006 to 2016, the State Department of Public Health, with funding from the Mental Health Services Act, created the California Reducing Disparities Project (CRDP). It funded 35 community-based nonprofit organizations throughout the state to work with different priority populations to demonstrate the effectiveness of their CDEP in reducing mental health disparities (Abe et al., 2018). The Fresno Center and their CDEP project, the Hmong Helping Hands Intervention (HHHI), was one of the 35 community-based nonprofit organizations selected to work with the Hmong population in the Central Valley.

We contend that mental health interventions that take account of a group’s unique “culture” and social-economic circumstances and that are implemented by a culturally and linguistically competent staff can be effective at reducing psychological stress and reinforcing the protective factors of the members of such group. Sociologist Ann Swidler (1986, p. 273) defines culture as a “‘tool kit’ of symbols, stories, rituals, and worldviews, which people may use in varying configurations to solve different kinds of problems.” From this point of view, culture provides the materials from which individuals and groups make sense of and construct different

strategies of action. By social-economic circumstances, we mean the social environment and economic/material conditions in which people live, work (retire), and interact with other people. The Hmong Helping Hands Intervention project takes account of both Hmong's existing stories, symbols, rituals, and worldviews and their unique social circumstances as refugees living in a society where they are often socially isolated from the larger society and where poverty, discrimination and other life stressors are common. This is seen in HHHI's design of the five key activities (also known as, components) for Hmong adult clients, such as Hmong Talk, Beautiful, Exploring, Cultural Therapeutic Arts and Crafts Activities, and Spiritual Healing (of which more below). These components draw directly on Hmong's cultural worldviews, stories, and rituals to design specific activities (or practices) that members of the Hmong community have defined as culturally relevant to them and other Hmong. In addition, in response to one of the most persistent problems that Hmong adults face which is the paucity of health care providers who are linguistically and culturally competent, the HHHI hired staff who are all linguistically and culturally competent.

Purpose and Research Questions

The Hmong Helping Hands Intervention is a direct prevention and early intervention project. The purpose of this research on HHHI was to learn how to help reduce depression, anxiety, and acculturation issues in Hmong adults and older adults by improving their physical, psychological, social, and spiritual well-being; to increase their knowledge and awareness of mental health issues; and to reduce negative outcomes that may result from untreated illness or individuals with risk or early onset of mental illness. Related to these purposes are concerns about psychological distress, daily life functioning, and present and recent cultural protective and risk factors.

This study addressed the following Research Questions:

1. To what extent has HHHI reduced participants' psychological distress?
2. To what extent has HHHI reduced participants' experiences of interference from negative emotions?
3. To what extent has HHHI strengthened participants' sense of connection and belonging?
4. To what extent has HHHI strengthened participants' beliefs in the value or importance of their culture or spiritual/religious traditions?

Methods

The design for the Hmong Helping Hands Intervention was a pre-experimental pretest and posttest single group design. The project consisted of three cycles of weekly sessions run over a 6 month period at three locations. Data was collected from participants immediately before the program started and again one week after it ended.

Participants in the Hmong Helping Hands Intervention program are Hmong adults and older adults in Fresno, Merced, and Stockton who showed some mild to severe signs and symptoms of mental health problems. Initial participants were recruited through word of mouth and with flyers and additional participants were recruited through these initial participants in a snowball fashion. To be included in this study, the participants needed to be healthy enough to fully engage in all of the HHHI designed activities. All participants were informed of their right to choose whether or not to participate in the study and informed consent was obtained from each participant using either a verbal or written consent form. This study was approved as exempt research from the Committee for the Protection of Human Subjects of the California Health and Human Services Agency.

A total of 113 participants were recruited, and only nine persons dropped out, for an 8% attrition rate, leaving 104 Hmong adults who were recruited and completed the HHHI project. Reasons for attrition were health issues, moving out of the area, and supporting childcare needs. The number of participants by cohort and gender appear in Table 1. A total of 65 (or 60%) of the participants were 59 to 64 years of age, 24 (22%) were older than 65, and 20 (18%) were younger than 59 years old. The participants included 94 females (83%) and 19 (17%) males. Also, almost all of the participants are illiterate in both Hmong and English.

Table 1. Characteristics of Hmong Helping Hands Intervention Participants 2018 – 2020

Cohort	Males		Females		Total	Attrition		Completion	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	<i>n</i>	%	<i>n</i>	%
Cohort 1									
Location 1	6	26	17	74	23	2	9	21	91
Location 2	1	11	8	89	9	0	0	9	100
Location 3	0	0	4	100	4	1	25	3	75
Cohort 2									
Location 1	4	19	17	81	21	3	14	18	86
Location 2	1	9	10	91	11	0	0	11	100
Location 3	0	0	7	100	7	1	14	6	86
Cohort 3									
Location 1	5	24	16	76	21	2	10	19	90
Location 2	2	12	15	88	17	0	0	17	100
Overall Total	19	17	94	83	113	9	8	104	92

Instruments

All items and variables in this study were measured with the State-Wide Evaluation (SWE) Core Assessment Instrument (Psychology Applied Research Center, 2021). Parts of this 63-item instrument were used by all entities who received funding through the California Reducing Disparities Project grants which funded the HHHI. This instrument was meant to be taken by participants who read items and recorded their responses with paper and pencil. This widely used procedure presented special problems for this Hmong sample most of whom do not read or write English or Hmong. For this reason, all survey items were translated into Hmong. During the administration of the translated survey, a facilitator read each of the survey questions aloud while trained bilingual staff sat alongside and assisted participants in understanding their responses and penciling in their answers while not influencing their responses. The SWE was administered in a group setting at each of the locations before the project started and a week after its completion.

The variables for the first and fourth research questions were originally coded on a 5-point scale, but this was reduced to a 3-point scale. The reason for this reduction in coding usage was that those who administered the instrument felt the participants might not have the same understanding of these codes measured on a continuum as the designers of the instrument intended, which potentially could have affected the reliability of the instrument (Shaw et al., 1991).

Initially all variables were coded so that a higher score indicated less of the trait being measured. As per the SWE manual, all items then were recoded so that high scores indicated more of the construct being measured. Finally, the scores for the first six items were summed into a subscale titled Psychological Distress. The next five items were summed into the subscale

Emotional Interference in Functioning, the next two items into Recent Cultural Connections - Protective Factors, the next two items into Recent Cultural Connections - Risk Factors, and finally, the last four items were summed into the subscale, Present Cultural Connections. The SWE Manual recommends using these composite subscales in statistical modeling. No satisfaction data are available.

Cronbach's alphas were calculated for pre and post subscales of psychological distress, functioning, and present cultural connections, and these (See Table 3) vary from .75 to .86 which are all in the acceptable range. For recent cultural connection protection and risk there were only two items that were summed for each so calculating a Cronbach alpha is not recommended. In these two cases, Pearson's correlations are presented (See Table 3), which range from -.10 to .52, which are low. No validity information is available either in the SWE Manual or for this study, though the items (See Table 2) appear to have face validity.

Intervention

The intervention consisted of five components with each component based on a cultural practice and relevance in the Hmong community. These cultural practices have historically been instrumental in the Hmong community's resilience and perseverance as a minority group of people who have gone through wars, trauma, poverty, and persecution. These components included the following: Hmong Talk; *Ncig Teb Chaws* (Exploring); Cultural Therapeutic Arts and Crafts Activities; *Maij-Maij* (Beautiful); and Hmong Spiritual Healing.

The following are brief descriptions of the five components of the HHH Intervention: (1) Hmong Talk – Hmong Talk was based on the Hmong cultural practice of *Qhuab Ntuas*. When a person or family is at a loss in their life or does something negative and needs new directions or guidance, the family will seek the help of a wise person to come and “lecture” them. This lecture

is seen as a spiritual blessing talk to help the family gain new insights, meaning and strength.

Hmong Talk was held once each month, and a prominent and respected Hmong figure from the community gave the talk.

(2) *Maij-Maij* (Beautiful) – This component operated on the premise that if a person feels physically beautiful, that person will feel emotionally happy. It focused on grooming, hygiene, and positive thinking to foster a positive image of oneself and an appreciation of oneself.

(3) *Ncig Teb Chaws* (Exploring) – This component was a way for Hmong people to become familiar with the environment and its natural resources. Traditionally, Hmong families moved from one village to another (mostly on foot) and knew their surroundings; however, in America, their new host society, Hmong older adults often encounter barriers that prevent them from travelling, such as living in communities being too far removed from one another and almost always needing vehicles in order to get from one location to another. This situation can foster a sense of isolation and disconnection. *Ncig Teb Chaws* involved three to four hour trips to nearby places such as Sacramento and the Pacific coast to encourage cross-cultural learning.

(4) Cultural Therapeutic Arts and Crafts Activities (C-TACA) – This component involved arts and crafts employed therapeutically to help people to cope with depression and anxiety and to develop a sense of meaning and purpose in their lives. These arts and crafts activities included traditional arts such as hand embroidery and flute playing as well as adopted artforms such as cardmaking and dancing.

(5) Spiritual Healing – The Hmong believe that spirituality plays a significant role in health and illnesses. They believe that the health and wellbeing of a person is dependent on that person having a healthy body, soul and spirits—that is, when the soul and spirits are “united” or “in harmony” with the body. When a person’s soul or spirits are not in harmony with the body,

illnesses can occur. In the Spiritual Healing activity, respected community elders collaborated with participants on various cultural healing practices to empower and restore their inner strength.

Besides these five culturally relevant activities, at every weekly meeting, a light cultural meal was provided in the morning or during lunch time for participants. Preparation of the meal was labor intensive for the staff but it was an important and culturally relevant practice of the HHHI project as Hmong adults view meals as a way of respecting them and their time.

The HHHI project had three cycles from August 2018 to March 2020, and each consisted of weekly sessions and were 6 months in duration. For each cycle, the project was initially run at three locations, but later one location was closed due to insufficient resources to hire enough staff. The entire project ended in March 2020 because of COVID-19 restrictions.

The HHHI recruited a capable and hard-working, bilingual, bicultural staff with appropriate skills, including fluency in speaking Hmong, familiarity with Hmong culture, and respect for elderly clients. It offered one of the most promising, compelling, helpful, and successful arrays of services available for older Hmong populations. All project sessions and materials were designed and conducted in Hmong by Hmong staff and counselors. Staff were also responsible for transportation for all clients, a considerable task.

Analyses

For all items for both the pretest and the posttest, the frequencies and percentages were run for all data. Only missing data were not included in these analyses. A one-way repeated measures MANOVA was performed on all five subscales using time (pretest and posttest) as the independent variable. For the multivariate results, the overall results for time included Wilk's lambda, F, df, p, and partial eta². The pre and post means, pre and post standard deviations,

Cronbach’s alphas, F’s, df’s, p’s, and partial eta²’s for all SWE subscales were also calculated. These statistical analyses were calculated on data with listwise deletions which is how these analyses must be conducted.

Results

The overall repeated measures MANOVA is significant (Wilk’s Lambda = .491, F = 15.546, df = 5,75, p <.001, partial eta² =.509). This multivariate result indicates differences between pre and post outcomes, and an examination of univariate results is needed for further interpretation.

Psychological Distress Analysis

The univariate results for research question 1 for Psychological Distress is significant at F = 30.008, df = 1,79, p <.001, partial eta² = .275 (See Table 2). These results coupled with a drop of mean distress from 14.85 to 10.53 and 27.5% of the variance explained shows a meaningful and promising decrease in psychological distress. The frequencies of scores for all items decreased indicating an improvement on these measures. The answer to research question 1 is that participation in the HHH Intervention resulted in reduced psychological distress. This result has far-reaching implications as indicators of psychological distress such as depression and hopelessness are often considered intractable.

Table 2. Frequencies and Percentages of Responses for All SWE Items by Subscales

		n	%	n	%	n	%
		None of the time		Some of the time		All of the time	
<u>Psychological Distress</u>							
In the past 30 days did you feel...							
Nervous?	Pre	10	8.8	56	49.1	48	42.1
	Post	17	17.5	61	62.9	19	19.6

Your culture helps you to feel good about who you are	Pre	1	0.9	7	6.1	106	93.0
	Post	1	1.0	6	6.2	90	92.8
You feel connected to spiritual/ religious traditions of your culture	Pre	1	0.9	12	10.5	101	88.6
	Post	2	2.1	9	9.3	86	88.7
<u>Recent Cultural Connection - Protection</u>				None of the time	Some of the time	All of the time	
In the past 30 days did you feel...							
Connected to your culture?	Pre	7	6.1	63	55.3	44	38.6
	Post	1	1.0	23	23.7	73	75.3
Balanced in mind, body, spirit and soul?	Pre	15	13.2	65	57.0	33	28.9
	Post	2	2.1	47	48.5	48	49.5
<u>Recent Cultural Connection - Risk</u>				None of the time	Some of the time	All of the time	
In the past 30 days did you feel...							
Marginalized or excluded from society?	Pre	26	23.0	65	55.6	22	19.5
	Post	50	51.5	32	33.0	15	15.5
Isolated and alienated from society?	Pre	44	38.6	55	48.2	15	13.2
	Post	58	58.6	26	26.3	15	15.1

Emotional Interference with Functioning Analysis

The research question for Emotional Interference with Functioning is significant at $F = 22.243$, $df = 1,79$, $p < .001$, $\text{partial } \eta^2 = .220$. The preferred outcome for this test is a decrease in this subscale and all items. The results of a drop of mean interference in functioning from 5.37 to 3.86, and 22.0% of the variance explained shows potential for a meaningful increase in functioning due to a decrease in interference (See Tables 2, 3). The answer to research question 2 is that HHH Intervention participation resulted in a reduction in participants' experiences of interference in daily functioning from negative emotions.

Recent Cultural Connection for Protection and against Risk.

The third research question addresses two constructs: Recent Cultural Connection for Protection and Recent Cultural Connection against Risk. The results for both protection ($F = 45.571$, $df = 1,79$, $p < .001$, $\text{partial } \eta^2 = .366$) and for risk ($F = 18.025$, $df = 1,79$, $p < .001$, $\text{partial } \eta^2 = .186$) are significant. Both of these results are in the preferred, hypothesized direction. There is a significant increase in recent protection from 6.95 to 8.65 and a significant decrease in recent risk from 5.48 to 4.15 with 36.6% and 18.6% of the variance accounted for, respectively.

Present Cultural Connections

Only the results for the last research question about Present Cultural Connections ($F = .784$, $df = 1,79$, $p = .379$, $\text{partial } \eta^2 = .010$) were not significant (see Table 3). Here the pre and post means are almost identical ($M_{\text{pre}} = 15.75$, $M_{\text{post}} = 15.64$) and only 1% of variance is explained. The items for this subscale are Strength My Culture Gives Me, Importance of My Culture to Me, My Culture Helps Me Feel Good about Who I Am, and Feeling Connected to the Spiritual/Religious Traditions of the Culture I Was Raised In. The percentages of participants who indicated “agree” on the pre-survey were 92.1%, 94.7%, 93.0%, and 88.6%, respectively. The percentages of participants who indicated “agree” at post-survey were 84.5%, 91.8%, 92.8%, and 88.7%, respectively. These data indicate that most participants had positive cultural and spiritual values at pre-survey, a preferred outcome, and stayed that way at post-survey. These very high levels of agreement resulted in very low variability (1%), and so there was no difference for this subscale though participants’ values and beliefs in the importance of their culture and spiritual traditions is uniformly high.

Table 3. Means, standard deviations, Cronbach’s alphas, F’s, df’s, p’s, and partial eta squares for all SWE subscales

Subscale	Mean	Standard Deviation	Cronbach’s alpha	F	df	p	Partial Eta²
Present Cultural Connections							
Pretest	15.75	.703	.77	.784	1,79	.379	.010
Posttest	15.64	.945	.86				
Recent Cultural Connection – Protection							
Pretest	6.95	1.855	.34*	45.571	1,79	<.001	.366
Posttest	8.65	1.519	-.10*				
Recent Cultural Connection – Risk							
Pretest	5.48	2.081	.37	18.025	1,79	<.001	.186
Posttest	4.15	2.460	.52*				
Psychological Distress							
Pretest	14.85	5.139	.75	30.008	1,79	<.001	.275
Posttest	10.53	5.752	.80				
Emotional Interference in Functioning							
Pretest	5.38	2.410	.76	22.243	1,79	<.001	.220
Posttest	3.86	2.109	.79				

NOTE: In cases where a subscale only has two items, calculating a Cronbach’s Alpha is not recommended. A Pearson’s correlation is presented instead.

Discussion

The community-defined evidence practice project, the Hmong Helping Hands Intervention, was created for Hmong adults and older adults to reduce their psychological distress and interference from negative emotions and to strengthen connection, belonging, and Hmong cultural and spiritual beliefs and values. Four research questions were examined. For the first three questions, all variables showed improvement and tests were significant. For the fourth research question, the results were not significant, but the data showed a very high percentage of agreement on positive statements about Hmong culture and spirituality.

One of the main ways that this study contributes to the effectiveness of practice-based evidence and culture as a protective factor is that depression and psychological distress are largely considered intractable conditions. However, for this sample the results demonstrated that these conditions can change for the better. The results of this initiative were overwhelmingly positive in terms of psychological improvements and maintenance of Hmong values. This is true even for conditions such as depression, which is commonly thought to be recalcitrant and difficult to change especially in this population which has experienced so much trauma and upheaval.

What is novel about the HHHI is that the set of activities—Hmong Talk; *Ncig Teb Chaws* (Exploring); Cultural Therapeutic Arts and Crafts Activities; *Maij-Maij* (Beautiful); and Hmong Spiritual Healing—was inspired by Hmong’s extent cultural practices/rituals and informed by input from members of the Hmong community who had defined such activities as relevant to their ethnic/cultural identity and wellbeing. HHHI focused on supporting traditional Hmong cultural beliefs, personal self-worth, and spiritual values so it can be viewed as Hmong-centric. The Hmong participants came to the HHHI project with a strong belief system that they retained

during the project, which likely parallels the resilience they demonstrated by maintaining their values through the trials of war, refugee camps, and resettlement. It is likely that the care and support they felt during the project enabled them to experience a comfort level and a pride in being Hmong, which opened them to changing and overcoming their depression and anxieties. It is also likely that the activities, along with the weekly meals and consistent support of an experienced bilingual and bicultural staff created a safe and supportive environment for participants to be with their contemporaries in a positive social setting. This opportunity to be together in a positive social setting is an important cultural protective factor for Hmong adults and older adults, many of whom openly discuss their feelings of sadness and loneliness because of social isolation. Once participants felt comfortable and connected to the peer participants in their social settings, they were more likely to want to attend program activities and to engage in activities together. One of the most consistent feedback from participants is that they enjoy other people's company and doing things together, suggesting that participants feel supported and validated. This finding is consistent with past research which suggests that culturally relevant community-based advocacy and collaborative learning opportunities provided to Hmong participants had positive, albeit limited effects on participants' mental health (Goodkind, 2006). More specifically, instead of focusing on a discourse of vulnerability, community-based advocacy and learning opportunities that recognize Hmong refugees' strength and resiliency and validate their experiences, knowledge and culture as important can have a positive effect on Hmong refugees' mental health (Goodkind, 2006).

It is important to consider how this type of project could be sustained and institutionalized in refugee and minority communities. In terms of process evaluation, the first challenge of the HHHI community-defined evidence practice was to create project components

that would be attractive to Hmong elders and would foster positive outcomes. To accomplish this, the first action was to hire fully fluent bilingual and bicultural staff who have intimate knowledge about and insights into the Hmong culture. This staff created the five components described earlier in this paper. This process was complicated by having staff in three different locations. However, they met regularly, worked diligently, and reached consensus in developing the components which were meaningful to and well received by the participants.

Logistical concerns primarily involved funding/hiring, recruitment of participants, and transportation. While the HHHI was funded by the state and was initially intended to be offered in three different cities, difficulties in hiring forced the closure of one of the project sites. The other two sites remained fully functional for the duration of the grant, although the HHHI was later forced to cease due to COVID. Recruitment was done through word of mouth and fliers, and though initially it was thought that recruitment would be more challenging, it was quite successful with 104 participants completing the entire project. This outcome supports a recognition that communication within the Hmong community is active and effective.

The final and most challenging logistical issue was transportation. These Hmong participants usually did not drive and had limited access to transportation as the family members whom they depended on had other commitments such as work or childcare or limited access to vehicles. To address this issue, staff coordinated closely with family members to help drive participants to sessions. Whenever possible, staff asked each participant to engage family members to help ease transportation demands. Although this might have been burdensome for some family members, by working collaboratively with them, staff were able to educate and show how their support was contributing and helping the participants. In addition, grant funds were specifically designated for transportation only. For those who had no other means of

transporting themselves to the center, staff went to pick them up and drop them off weekly, and they were reimbursed for mileage. This, however, was very demanding on staff though they rose to the occasion, and they made sure participants attended all sessions. For the Ncig Teb Chaw (Cross Cultural Learning Exploration) component, the majority of the participants could not drive themselves to the exploration sites, so charter buses were rented to transport them.

The last set of challenges was linguistic. Although Ly (2016) found that language was a barrier to Hmong participation in community activities, this was generally not a problem with the HHH Intervention. All project sessions were conducted completely in Hmong with all participants and staff being fluent. Here again, hiring all staff who are fluent in Hmong and culturally aware and sensitive was essential to participant satisfaction and the success of this project. However, there were some complications with the administration of the state mandated evaluation instrument. The intent for the administration of this instrument was that it should be given as a paper and pencil survey. However, this instrument had to be translated into Hmong. Also, since most of this sample of participants do not read or write, a facilitator read each question while a staff member helped each person record their responses. Staff also clarified any questions that participants had while maintaining an impartial stance so as not to influence responses.

Limitations and Conclusion

The Hmong Helping Hands Intervention was created specifically for Hmong adults and older adults to reduce their psychological distress and to strengthen their protective factors. The results showed awe-inspiring positive outcomes for psychological improvements and maintenance of Hmong values despite Hmong participants' past experiences with numerous traumas. The successful, positive outcomes of this CDEP project offer a guide to others who,

with the right setting and support, may also be able to design activities that can help clients reduce or overcome psychological distress.

Nevertheless, as with any study and program, there are some limitations. As a quasi-experimental study where participants were not randomized to their respective interventions, there is the possibility that some of the results we see here could be due to confounding factors we do not know of. While the pre-and post-participation responses suggest encouraging improvements in participants' psychological and emotional well-being, it remains difficult to determine the extent to which these changes can be attributed solely to the project. Some of the improvements may also reflect other external influences, such as evolving family dynamics at home.

Also, because our sample of participants was recruited by word of mouth, it is possible that some participants, especially those who know each other, may have behaved or thought alike when it comes to doing or reporting certain things, including perhaps making similar self reports about their health, psychological wellbeing, or distress or lack thereof. This project was designed specifically for the Hmong adults and older adults who were mostly monolingual speakers, and may not fit the needs of Hmong of other ages who are dealing with different issues or are bilingual. In spite of these limitations, we think that the findings of this study offer hopeful clues for other community defined evidence practices aiming to intervene in the health of immigrant groups like Hmong Americans.

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